

REQUEST for STAKEHOLDER COMMENT

Design and Development of an Insurance Exchange in Connecticut

The following information is organized by general topic area, with a list of questions we would like you/your organization to answer as you feel appropriate. These questions are followed by background briefings to provide a general understanding of the topics. To encourage productive discussion during each meeting, we are providing you this information in advance of your meeting. While these topic areas are the specific issues for which public comment is requested, please feel free to offer any other comments on policies related to the Exchange and the insurance market as well.

This information is submitted from:

Name: Joseph Treadwell, D.P.M. Phone: (203) 748-2220
Organization: Connecticut Podiatric Medical Association Email: jtread6692@aol.com
Address: 342 N. Main St., #301, West Hartford, CT 06117-2507

QUESTIONS

Please provide us with your thoughts and insights on the questions listed below as you feel appropriate.

CPMA has limited its comments to those questions on which it believes it can provide valuable insight and input.

A. Establish a Responsive and Efficient Structure

- I. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?
2. Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools.
3. Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?
4. Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval?

B. Address Adverse Selection and the External Market

- I. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange? Under a dual market scenario, what additional rules should Connecticut

establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange?
3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

C. Simplify Health Insurance Purchase

- I. What issues should Connecticut consider in establishing a Navigator program?

CT should ensure that those providing assistance under the Navigator program are free of any conflict of interest that could influence them to direct consumers to particular options.

In addition, the key to a successful navigator program is providing those assisting consumers with information and tools that provide the ability to identify the best option based on individual factors. This issue is discussed in further detail below.

2. What should Connecticut consider regarding the role of insurance brokers and agents?

Agents and brokers can be useful in assisting consumers in choosing a health plan and explaining their options. However, the state should ensure they are not unduly influenced by commissions by regulating the range of commissions payable by health plans so that there are not great disparities between plans. In addition, agents should not be allowed to sell plans in the exchange until they have been appropriately trained and have demonstrated their understanding of relevant factors by performing at a minimum level on a test. Health plans should be held responsible for oversight of agents selling their plans.

D. Increase Access to and Portability of High Quality Health Insurance

- I. Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?

CPMA believes that competition will ultimately benefit consumers. Thus all plans that meet criteria for certification as a Qualified Health Plan should be made available through the exchange.

However, to ensure that all plans sold through the exchange are administered in a transparent, predictable and consumer friendly manner, CPMA believes that CT should adopt a range of criteria that must be met in order for plans to be certified as Qualified Health Plans. Such criteria should include, but not be limited to, (1) Use of a standard definition of medical necessity across plans. CPMA believes that podiatrist and other physicians should have input in assisting the state in adopting this definition; (2) Disclosure of a broad range of information necessary for consumers to make meaningful plan choices, to understand the rules of the plan, including any restrictions imposed on accessing benefits, and to understand their rights and responsibilities; (3) Use of a standard code editing package, specifically those included in the National Correct Coding Initiative so that physicians are able to predict how they will be paid for providing services and thus inform patients of their coverage; (4) Access standards that ensure that consumers have access to the range of providers available to treat their

medical conditions. Such standards would consider number of providers, geographic availability, and choice of a range of types of licensed providers ; (5) Coverage policies that ensure that consumers can choose to receive services from any type of health care provider who is licensed to provide a covered service (subject to any applicable network restrictions).

2. Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care?

CPMA believes that individuals should be eligible for federal subsidies to purchase exchange plans rather than establishing a basic health program. Individuals with incomes of 133 percent to 200 percent of FPL should have access to the range of plans offered through the exchange. We believe that such a structure can limit adverse selection in the exchange and increase the number of individuals participating, thereby better spreading risk. In addition, federal law cost-sharing subsidies for individuals at or below 400 percent FPL and increases in the actuarial valuation of Silver level plans for individuals with income at or below 200 percent FPL will limit the potential out-of-pocket costs for lower income individuals who purchase coverage through the Exchange, and obviate the need to establish a Basic Health Program.

3. How would the Basic Health Program impact other related programs in Connecticut?

N/A

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)

By not establishing a basic health program and allowing individuals to purchase subsidized coverage through the exchanges, CT will allow those individuals to choose to remain enrolled in the same health plan if their income exceeds 200 percent of FPL.

E. Ensure Greater Accountability and Transparency

- I. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?

In order to most effectively engage consumers, information should be provided in a comparative manner and through a mechanism that takes into account individual factors. For example, by providing an online mechanism such as that offered under the Medicare Plan Finder at Medicare.gov that can show consumers their potential cost sharing based on their health status and can inform consumers regarding whether the maintenance drugs that they take are on the health plan's formulary and what their cost sharing will be for those drugs. Information provided in such a manner allows beneficiaries to more quickly and easily choose the health plan that is right for them. Beneficiaries should also have a mechanism to determine whether their health care providers are included in the health plan's network and whether there would be any restrictions on the use of that provider – such as prior authorization requirements, referral requirement or differences in cost sharing.

This mechanism should be available to those assisting consumers through the navigator so that consumers who do not have access to a computer or do not have computer skills also have access to this valuable information.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?

Connecticut should establish a mechanism for consumers, providers and others affected to file complaints or raise compliance issues. To the extent the complaints involve health plans, the state should require health plans to respond to these complaints within a set period of time. Moreover, the state should track complaints to identify health plans that are outliers or that otherwise have compliance issues. To the extent the complaints involve other components in the system, the state should track those complaints to identify opportunities for improvement. In addition, the state should provide a formal process under which stakeholders have a periodic opportunity to submit input on the different components of the system.

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?

Plans should provide a broad range of information in order to provide consumers the opportunity to make meaningful choices. Such information should include: the percentage of claims denied, percentage of appeals overturned, numbers of member grievances, results of consumer satisfaction surveys; explanations of any restrictions on access to providers including explanations of any tiering programs, limits on out-of-network benefits, referral requirements and prior authorization requirements; full disclosure of the provider network in both paper and electronic form; and general information regarding any physician incentive arrangements (i.e., that physicians are capitated or paid a bonus based on amount of utilization). While ACA requires plans to disclose quality information, it is important that such information be balanced between process and outcome measures and explained to consumers. For example, to the extent that any measures look at cost, it should be disclosed. Moreover, physicians should have input on the quality measures ultimately adopted in order to evaluate health plans.

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?
2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?
3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?

CT should ensure that benefits are defined by the type of services provided rather than the type of physician or other provider furnishing the services. As long as a covered service is within the scope of services for which a particular type of physician or other provider is licensed, such service should be reimbursable. For example, a separate podiatry benefit would be unacceptable. However, podiatrists should be able to furnish any covered services within the scope of their licensure and be reimbursed for that service.

In addition, Qualified Health Plans should be required to provide state mandate benefits.

- G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.
1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?
 2. Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?
- CPMA believes that competition ultimately benefits consumers. Thus, we believe that all health plans that meet the definition of qualified health plan and who do not have consistent compliance issues or low quality issues should be able to participate in the exchange.
3. Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?
 4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?
 5. What should be the role of the Exchange in premium collection and billing?
 6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

BACKGROUND by TOPIC AREA

The general information on each topic area below is intended for brief reference only.

A. Establish a Responsive and Efficient Structure

The ACA requires that all states establish an American Health Benefits Exchange for the individual market and a Small Business Health Options Program (SHOP Exchange) for the small group market. States may operate these independently or may combine them into a single Exchange. States may also form regional or multi-state Exchanges.

For the purpose of inclusion in the SHOP Exchange, the ACA defines small employers as an employer with 2-100 employees. However, until 2016, states may limit this definition to 2-50 employees; and after 2017 states may further expand participation in the SHOP Exchange.

B. Address Adverse Selection and the External Market

The ACA allows states to establish a "dual market" in which individual insurance may be purchased in and out of the Exchange, or to require that all health insurance plans sold on the individual market must be sold through the Exchange. States may also design "hybrid" solutions such as permitting supplemental coverage to be sold in external markets but requiring that all individual major medical coverage be sold in the Exchange.

The ACA establishes certain rules to protect against selection issues in a dual market, but does not deny states the ability to include additional requirements for insurance sold in the Exchange and an external market. State options include but are not limited to requiring that all insurers in the Exchange offer all four tiers of coverage, standardizing benefits packages, and restricting the sale of "catastrophic" insurance plans. However at a minimum, the following rules apply:

- Plans inside and outside of an Exchange must be in the same risk pool, have the same premium rate (for those sold by the same company), and meet the same minimum benefits standards.
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre-existing conditions, medical status, or claims history.

- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange.
- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick.

The ACA requires that states establish a reinsurance program for the individual market inside and outside of the Exchange, for the first three years of Exchange operation. The NAIC will develop model legislation to carry out this provision. States must consider issues such as how to coordinate their high risk pools with this program.

C. Simplify Health Insurance Purchase

The ACA requires an Exchange to establish a “Navigator” program to conduct public education, advise individuals and small groups that enroll in the Exchange, help them enroll in health plan and access benefits, and provide referrals as needed to the health care ombudsman. The Navigator program must be established by awarding grants to a variety of groups, and must be financed through operational funds of the Exchange (not Federal funds received by the state to establish the Exchange).

With establishment of an Exchange, the existing relationship between brokers, carriers, and consumers is likely to change. The ACA leaves states flexibility to make decisions regarding these relationships, such as designating an official role for brokers within the Exchange apparatus, requiring certification, or regulating commissions.

D. Increase Access to and Portability of High Quality Health Insurance

The ACA requires that health plans that wish to participate in an Exchange (Qualified Health Plans) comply with certain requirements related to marketing, choice of providers, plan networks, and essential health benefits. Beyond this, states may establish additional requirements for plans that are offered on an Exchange.

The ACA provides states with the option of operating a Basic Health Program for individuals between 133% and 200% of the federal poverty level, in lieu of those individuals receiving premium subsidies for purchase of coverage. The benefits under the Basic Health Program must be at least equivalent to the essential health benefits and premiums may not be higher than those in the Exchanges.

With health care reform, individuals may be eligible for one of a variety of insurance options: Medicaid, CHIP, subsidized coverage through an insurance Exchange, and unsubsidized coverage through an Exchange. The ACA requires that there should be a single seamless process of applying for coverage for all of these programs – regardless of where a consumer enters the system.

E. Ensure Greater Accountability and Transparency

The ACA requires that Exchanges post information on the cost and quality of health plans. Specifically, states must develop an Internet website for standardized comparative information on plans, provide public ratings of participating Exchange plans, and use a standard format for presenting health plan options in the Exchange.

F. Self-Sustaining Financing

The ACA includes grant funding for planning and establishment of Exchanges, but beginning January 1, 2015, state Exchanges must be financially self-sustaining.

The ACA establishes a minimum essential benefit set to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of those benefits for individuals eligible for tax credits through an Exchange.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

Under federal law, the Exchange is required to perform these functions:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS)
- Operate a toll-free customer assistance hotline
- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers
- Assign a rating to each qualified health plan under the rating system that will be established by HHS
- Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions
- Inform individuals about the existence of—and their eligibility for—public programs, including but not limited to Medicaid and Children’s Health Insurance Program (CHIP)
- Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS
- Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage
- Provide information to employers on their employees who are not covered
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits